Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1774AGC	A. BUILDING _____ B. WING _____	C 05/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOYALTON OF LAS VEGAS	3025 E RUSSELL ROAD LAS VEGAS, NV 89120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility 5/11/09 to 5/13/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. Complaint #NV00021567 and #NV00021825 were substantiated. See Tag Y878	Y 000	Acceptable POC 6/15/09 Debra L Seeger RN Debbie Baquet 6/16/09	
Y 878 SS=H	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on interview and record review from 5/11/09 to 5/13/09, the facility failed to ensure all medications prescribed by a physician to 10 of	Y 878		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Marcia C Hansen TITLE ED (X6) DATE 6-12-09

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Y 878	Continued From page 1 20 residents were administered to the residents. (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10) Findings include: Medication administration records (MAR) for 10 residents were reviewed during the complaint investigation: Resident #1: Prescribed an Exelon patch (for slowing memory loss) to be applied everyday. The patch was unavailable on 4/11/09 and 4/12/09. Vitamin C, one tablet every day, was not available from 5/4/09 to 5/12/09 (nine doses). Resident #2: The resident's physician placed a hold order on Coumadin for two days, 4/9/09 and 4/10/09. The facility did not begin administering the Coumadin until 4/12/09 so the resident missed her 4/11/09 dose. Resident #3: The resident was prescribe Lorazepam, 0.5 mg, two times a day. The medication was not given at 12:00 PM on 5/5/09 because the facility was waiting for a refill. Resident #4: The resident was prescribed Clonazepam 0.5 mg, one at bedtime and did not receive five doses of the medication from 5/1/09 to 5/5/09 because the facility was waiting for a refill. The resident was prescribed MAPAP caplets (Tylenol with Codeine), 500 mg, three times a day for pain. The resident did not received 27 doses of the medication from 5:00 PM on 5/5/09 through 8:00 AM 5/12/09 because the facility was waiting for a refill. Resident #5: The resident was prescribed Morphine Sulfate (for pain), 30 mg, one table every 12 hours. The resident did not receive 16	Y 878	Y878 Resident numbers 1, 2, 3,4,5,6,7,8,9 & 10's medications were all reviewed and are in the community. Medications will be given as prescribed. The medication records of the other residents that reside in the community will be reviewed for any medication discrepancies. Any discrepancies noted will be addressed and resolved in a timely manner. Med techs will be re-educated on the medication policy. An in-service will be held on 6/16/2009 The Wellness Coordinator or designee will be reviewing the Medication Administration Records with shift-to-shift Medication Administration Record review (see attachment). The Resident Care Director will be reviewing Medication Administration Records on an ongoing basis for missing meds or changes in orders.	

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Y 878	Continued From page 2 doses of the medication from 3/23/09 to 3/30/09; nor nine doses from 8:00 PM on 5/3/09 to 5:00 PM on 5/7/09 because the facility was waiting for refills. Resident #6: The resident was prescribed Advair (breathing treatment) two times a day. The medication technician initials were circled from 8:00 AM on 5/4/09 through 8:00 AM on 5/6/09 (5 doses) with no explanation on the MAR. Resident #7: The resident was prescribed Doxycycline 100 mg, two times a day for 10 days starting on 5/1/09 and it appeared she missed six doses. Medication technician's failed to initial the administration boxes for 8:00 AM on 5/2-3/09 but initialed that the medication was administered in the PM on 5/2-3/09; circled their initials 5/4/09 AM and PM, 5/5/09 AM and 5/6/09 AM. There was one notation on the back of the MAR for 5/4/09 PM that the medication was not given because it was not available. The resident was still receiving the medication on the day of the survey, 5/13/09. Resident #7 was also prescribed Ferrous Sulfate (Iron), one tablet every day. The resident missed 13 doses of the mineral from 5:00 PM on 5/6/09 through 5:00 PM on 5/12/09. Resident #8: The resident was prescribed Lasix (a diuretic) 40 mg, one time a day. The resident missed seven doses from 5/4/09 to 5/10/09 because the facility was waiting for a refill. Resident #9: The resident was prescribed Arphagan eye drops, one drop in each eye two times a day. The resident missed three doses from 5/5/09 through the AM dose on 5/6/09.	Y 878	Med Techs will notify the Wellness Coordinator when seven days of meds are left. If the family/caseworker provides the medications, we will contact them when seven days of meds are left. If the meds are not in one day prior to outage, we will order the necessary medication from the community designated pharmacy and bill the resident. If the resident currently uses the community designated pharmacy, all meds will be ordered when only a seven day supply is left. Follow up will be done on a daily basis by the Wellness Coordinator or designee to ensure medications are ordered in a timely manner. If the meds are not delivered via courier, the community will send for a pick up of the meds at the pharmacy. This will be monitored by the ED and RCD on an ongoing basis. Correction date: 6/16/2009	

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Y 878	Continued From page 3 Resident #10: The resident was prescribed Glipizide ER (for diabetes) 2.5 mg, one tablet 10 minutes before breakfast. The resident missed two doses from 5/6/09 to 5/7/09 because the facility was waiting for a refill. The resident missed three doses of Levothyroxine from 5/6/09 to 5/8/09, and five doses of Calcium 600 mg, two times a day, from 5/6/09 through 5/8/09. Severity: 3 Scope: 2	Y 878		